TIP SHEET: COVID 19 & NUTRITION

This Tip Sheet serves as guidance to help you think through options for mitigating the spread and impact of COVID 19. Use it to inform adaptation of nutrition programming in the context of COVID 19, as well as for generating ideas about new and expanded programming.

Please note that this is a living document and is subject to changes and adaptations according to the evolution of the COVID 19 response context. We therefore recommend frequent checks on the Digital Library for the latest version. Also, this is generalized guidance, and we are ready to work with you to tailor advice. If you have questions or need support, please contact the Nutrition technical advisor:

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Make sure that all staff and community volunteers follow the general Covid-19 guidance carefully, including Annex 11 Working in the Field During an Infectious Disease Outbreak - intended to keep you, other staff, and program participants safe and healthy. This tip sheet builds on existing guidance and should be used in partnership with it. You will find centralized information on the Hub's main page: https://thehub.mercycorps.org/

1. Community Engagement and Behavior Change Communication

Establishing trust, community engagement and ownership is incredibly important during a communicable disease outbreak. It increases acceptance of health information and messaging and helps in identifying potential solutions to primary and secondary effects of the outbreak. Top tips include:

- Ensure that local Health Committees, Community Health Volunteers and Care Group Lead Mothers are equipped with the information and tools to support their communities through the outbreak. Involve them and any other community leaders and important influencers in developing and implementing a community action plan, as well as identifying contextually appropriate messaging for different target audiences.

- Continuous reinforcement of health messaging and factual information about COVID 19 can help to counteract rumors and false information. Use locally appropriate dissemination channels and make sure that information is available in all local languages. Try to avoid any methodology that brings together groups of people and instead consider print media (with adaptations for low-literate populations), audio messaging, social media, whatsapp, SMS etc. Consider in particular how to reach the most vulnerable populations including the elderly and people with different forms of disability and chronic illness.

- Don't focus on 'messaging' alone. Seek to understand local barriers to behaviour change, including both physical impediments (such as poor access to water and soap) and socio-cultural factors (behaviour and influence of others, rumors, long standing beliefs and myths etc). This may differ hugely per community and among subsets of society. Work with

local actors to find practical means of addressing these barriers.

- Avoid contributing to a climate of fear and panic. Use positive messaging wherever possible (e.g. based around protecting family and community, being a 'good' son, daughter, father, mother etc) and avoid dramatic language or communication that could lead to scapegoating or add fuels to rumours.

For further guidance on Community Engagement, Risk Communication and Behaviour Change Communication in Crises consult the following:

COVID 19: Key tips and Discussion Points for Community Workers, Volunteers and Community Networks, IFRC/WHO/UNICEF

Risk Communication and Community Engagement (RCCE) Action Plan Guidance, IFRC/WHO/UNICEF

COVID 19 - How to include marginalized and vulnerable people in risk communication and community engagement, RCCE Working Group

2. Factors to Consider for Nutrition Programming

Focusing on preventing the spread of COVID 19 is clearly crucial but it should not make us forget affected people's other needs, nor the longer-term medical needs of the wider population. COVID 19 may impact nutritional status at the household, community, national, regional and even global level. Below are some of its potential knock on effects that may serve as drivers of increased malnutrition:

	Household	Community	National, Regional & Global
Food Security	● Hastily ordered quarantine measures may leave households with insufficient water, food, medicine and hygiene items. ● Illness, care-giving, and social distancing may keep people from engaging in income-generating activities, reducing purchasing power. ● Illness may cause households to divert money to healthcare costs, which would otherwise be spent on food.	● Social distancing may result in people avoiding marketplaces or job sites for fear of contracting the virus, curbing market activity ● Local food supply lines may be disrupted; food supplies at markets and grocery stores may be constrained with price increases for available products. Fresh produce in particular may be in short supply; stockpiling may decrease the availability / increase the cost of staple goods	● Reduced food production, changes in supply chains (including trade policies that restrict imports and/or exports of food or the movement of goods domestically), and reductions in migrant farm labor may constrain food availability and increase prices.

	• Illness, care-giving, and social distancing could keep people away from their fields and delay planting, harvesting, etc., reducing food production.	• School closures may mean that school feeding programs stop thereby increasing demand on household food consumption.	
Infant & Young Child Feeding (IYCF) & Care practices	• Severe illness may prevent or discourage caretakers from engaging in proper IYCF and care • Stress may affect milk let down leading mothers to worry about inadequate supply • Families may resort to infant formula or other breastmilk substitutes which expose infants to additional risks	• School closures are likely to increase the care burden and diminish time for adequate IYCF/care practices. • Care Groups/Mother Support Groups may be unable to meet and support one another due to rules on social distancing • Household visits by CHW/Vs may be reduced or suspended.	• In previous crises, infant formula producers have attempted to gain access to markets, often in the first instance via donations, undermining breastfeeding practices and endangering infant health.
Health & WASH	• Illness can impact appetite (~40% of COVID-19 patients have a marked loss of appetite) , absorption and energy needs and contribute to malnutrition • Gastrointestinal distress is a common symptom of COVID-19, which could have an impact on absorption and hydration • Social distancing or market disruption may make it difficult for households to access hygiene supplies (i.e. soap)	• Social distancing measures create many obstacles for access to both health and WASH services. • MNCH services will come under strain, including those strongly affecting nutritional status such as routine vaccination, IMCI, CMAM and ANC/PNC.	• Global health infrastructure will be constrained and current funding may be diverted. • Supplies of nutritional products such as RUTF, RUSF and CSB++ may be disrupted.
Gender & Social Inclusion	• In times of food shortage, some groups such as women, PWD and the elderly may be particularly at risk of 'going without'. This is particularly true if government directives suggest or require that vulnerable individuals stay home.	• Social services supporting vulnerable households - through schools, health clinics, etc., - may be overwhelmed • Stigma may lead to certain groups and individuals being ostracised and finding it even harder to access	

	● Increased risk of SGBV (in addition to time/care burdens) can put additional pressure on maternal mental and physical health leading to increased risk of maternal malnutrition, low birth weight babies (with medical complications) and difficulties with IYCF.	essential goods and services ● Poor access to information is often particularly acute among low literacy women, the elderly, people with disabilities and other marginalised groups.	

3. General Approach

- **Decide which nutrition program activities are absolutely essential** and which should be stopped or scaled back temporarily. Consider adaptations that minimise risk of disease transmission. The COVID Programme Contingency Planning Template can help structure this.

- Work with the RPT to communicate with your donor on **postponing all data collection efforts which require contact with communities** (e.g. baseline, endlines, assessments, etc.). Please review **Mercy Corps' Remote MERL Guidance** for more information.

- Work with program teams and technical experts to **revisit current indicators and targets**, and make adjustments that take into account program adaptations.

- Engage at national and sub-national level in **Nutrition Coordination mechanisms** to ensure joint analysis of the nutrition situation and ongoing provision of essential nutrition services.

- Work across sectors to identify opportunities to integrate health & hygiene promotion into program activities. Leverage all existing platforms, networks, and volunteers to assist in this.

- **Advocate both internally and externally for continued resources and attention to both preventative and curative services for malnutrition**. It is likely that for the short to medium term the focus of politicians, civil servants, health workers, humanitarians and donors will shift to COVID 19. While this is understandable, many lives will also be increasingly at risk from malnutrition. Ensure that this perspective is heard during response planning and coordination meetings (particularly HCT and Health Clusters). Ensure that whoever attends these meetings for Mercy Corps is briefed on this. In particular highlight the specific nutritional needs of young children orphaned or with severely ill mothers, as well as the need to promote and support continued breastfeeding as a life-saving measure.

4. Program Adaptation & Design Recommendations

As with all programming, context matters and **any response should be based on context-specific analysis.** Current programs should monitor for impacts of COVID 19 on nutritional status, as well as on the underlying drivers of malnutrition, in the communities in which they operate. In addition to your own monitoring efforts, partner with the Nutrition Cluster/Sector (where active) and the relevant national and local authorities to understand these impacts and the broader situation in-country.

As a general guide, think about how COVID 19 may impact the main underlying drivers of malnutrition, including food security (access, availability, quality and utilization), infant and young child feeding and care practices, access to health care, environmental factors and gender inequalities. Below are some possible options for program adaptations aimed at preventing increases in malnutrition during COVID 19:

Food Security	IYCF & Care Practices	Health & Environment
Consider food assistance that targets those most vulnerable to malnutrition (modality should be determined by a market and hygiene analysis). Provide grants to traders to jump-start markets that may have stalled in the wake of the crisis. As markets recover, consider cash grants to households to improve access to livelihood inputs lost or consumed in response to the crisis - including agricultural inputs if fields have been abandoned due to the crisis. For more information, see Mercy Corps' COVID-19 & Food Security Tips.	Use safe and contextually appropriate channels to enhance promotion breastfeeding regardless of the viral-status of mothers; emphasize handwashing with soap by caregivers; and consider distributing masks for breastfeeding mothers who may be ill to avoid transmission to her child (more from WHO, UNFPA). For affected communities, shift away from Care/ Support Group models until safe to resume. Prioritise individual counselling and support for difficult cases. Provide IYCF support specifically to Orphans and Vulnerable Children, particularly those under 2. In addition to age appropriate foods, this may require supplemental foods or breastmilk substitutes (infant formula), in line with the International Code/Ops Guidance on IFE (2017).	Avoid mass-gathering, whether it be malnutrition screenings, vaccination campaigns, distributions or health promotion activities. Consider whether your program design encourages or requires program participants to take public transportation or enter crowded areas to receive services, and adapt your programming to try and avoid this As part of preparedness, train and equip primary caregivers with the ability to screen for malnutrition at home, which avoids the need for mass screenings. In contexts already experiencing an outbreak, train CHW/Vs in "no touch" iCCM, malnutrition screening and basic hygiene promotion. Institute a system of household visits that prioritises at-risk families. Enhance measures to reduce exposure to COVID 19. Establish good practices for remote supervision.

		Work with WASH colleagues, local authorities and/or partners to identify hotspot areas and provide handwashing stations, as well as a continuous and sufficient quantities of soap and water in public spaces (clinics, markets, entrances to villages and towns), as well as households. For other WASH related measures see the WASH tipsheet and Global WASH Cluster resource guide.

Consider the gendered impacts of COVID 19, especially the increased burdens on time and caregiving. Work with communities to find locally acceptable solutions!

Community-based Management of Acute Malnutrition

Even with aforementioned preventative programming, it is likely that cases of acute malnutrition will increase during the pandemic. The Global Technical Assistance Mechanism (GTAM), in coordination with the Global Nutrition Cluster are currently formulating specific guidance on Community Management of Acute Malnutrition in light of COVID 19. This will be shared in due course. For those country programs that are confident of having the scope and expertise to work in Community-based Management of Acute Malnutrition (CMAM), here are some ideas on how to proceed in the meantime:

- **Coordinate with the Nutrition Cluster/Sector and national/local health authorities.** Stay up-to-date with any changes to the National CMAM Guidelines and/or any additional protocols put in place in response to COVID 19. Particularly for those in a position to shift or scale up CMAM support, engage in joint analysis and planning to identify priority areas and gaps in service provision.

- **For health facility based precautions and safety measures** the latest guidance and protocols from WHO can be found here. Currently for outpatients these focus on:
    - Triage and early recognition;
    - Hand hygiene and respiratory hygiene; Set up handwashing stations at the entrance and require hand-washing on entry and departure. Institute temperature checks on arrival where feasible.
    - Medical masks to be used by patients with respiratory symptoms;
    - Appropriate use of contact and droplet precautions for all suspected cases; prioritization of care of symptomatic patients;
    - When symptomatic patients are required to wait, ensure they have a separate waiting area;
    - Educate patients and families about the early recognition of symptoms, basic precautions to be used, and which health care facility they should go to. Make use of audio and visual IEC where possible.

- Where possible however, make adaptations to **reduce crowding in facilities** (both inside

and outside clinics) and **shift management of acute malnutrition to the community.**

- **Increase the take home allowance of RUTF.** Rather than expecting CMAM outpatients to attend clinic every week, consider shifting to a fortnightly ration. Another option, in coordination with UNICEF and local health authorities, may be to preposition supplies in affected and/or remote communities and train CHWs or local volunteers to manage them. Ensure that the systems are in place to follow up cases of SAM/MAM in the community and to monitor supplies.

- **Introduce family-led MUAC** (home screening for malnutrition) where feasible. This has proved to be an effective approach in the early identification of malnourished children in many contexts. In a situation where social contact is ill-advised a rapid roll out of family-led MUAC and other initiatives to increase family/community ownership of CMAM programs will help to ensure program continuity, avoid increased morbidity and mortality due to acute malnutrition and lower the risk of co-morbidity and medical complications. If shifting to family-led MUAC, ensure program participants know how (and have the resources) to reach out with questions or concerns.

- **Train Community Health Volunteers/Lead Mothers to diagnose and treat uncomplicated cases of acute malnutrition (referring only the severest of cases for inpati).** This can be either a complementary approach or an alternative approach to family led screening.

- Mobile Health Applications (MHealth) can help with remote management and provide an extra layer of support for over-stretched clinic staff. By **extending MHealth technology to the community level**, CHW/Vs could be further empowered to support uncomplicated cases of acute malnutrition, by providing a platform for remote training, monitoring and supervision.

- **Technologies such as Signpost and Viamo** can be used to inform households of (changes to) health and nutrition service provision, allow for tracking and transfer of acute malnutrition cases (through patient access to simple health records) and serve as a vehicle for health messaging. This is particularly useful for improving access and coverage of remote communities and populations in transit (pastoralists, refugees, IDPs). Please refer to the T4D tipsheet and feel free to contact T4D and the Nutrition Adviser to discuss which technology might be appropriate in your given context.

- For advice regarding ongoing **Supplementary Feeding Programs** please refer to WHO's COVID 19 guidance on mass gatherings, in addition to Mercy Corp's own internal guidance.

Universally, Remember Hygiene!

ALL TEAM MEMBERS should follow general COVID 19 guidance. Adopt culturally-appropriate, best practices on hygiene and social distancing in your program implementation, including hand washing, equipment disinfection, reducing proximity to program participants and between program participants in gatherings. In addition to MC Program staff, it is essential the Community Health Workers and Volunteers are trained to:

- Maintain a safe distance (2 meters) with any individual they are visiting
- Avoid all physical greetings with individuals (i.e. hand shake, hug, etc.)

- Wash hands for 20 second with soap and water or use an alcohol-based solution after touching surfaces in public places or people's homes (the means with which to do so should be provided by Mercy Corps).
- Hold meetings only if absolutely essential. Ensure that they are held outdoors or in a well-ventilated area, in a space large enough for a safe distance (2 meters) between individuals.
- Provide accurate information on COVID 19 transmission and prevention.

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